Hilltown Community Health Center

School-Based Health Programs
12 Littleville Road
Huntington, MA 01050
413-667-0142
www.hchcweb.org

GATEWAY REGIONAL SCHOOL BASED HEALTH CENTER

Childs Name_____Date of Birth__/__/___ Male { } Female { } Transgender { }
Street Address_____City_____State_____Zip_____
Mailing Address (if different)_____City_____State_____Zip_____
Phone Number (____)_____Social Security Number_____
Email_____School_____Grade_____Staff_____
Mothers Legal Name/Legal Guardian_____Daytime Phone (___) _____
Fathers Legal Name/Legal Guardian_____Daytime Phone (___) _____
Emergency Contact Name_____Phone number (____) _____

***Race/Ethnicity**?*
American Indian/Alaskan Native { } Asian { } Black/Non-Hispanic { } Hispanic/Spanish/Latino White/Not Hispanic { }
Native Hawaiian Islander { } More than 1 { } Other { }
~In what language do you prefer to discuss health related concerns? _____
~In what language do you prefer to read health-related materials? _____

Insurance Information:
Medical Insurance company_ _____Phone Number_____ City
_____State_____Zip code_____ Subscriber
Name_____DOB_____Social Security# of subscriber_____
Policy Number_____Group Number_____Name of Employer_____

Medical information:
Primary Care Physician_____Phone Number_____Fax Number_____
Address_____City_____State_____Zip Code_ _____
Pharmacy_____Phone Number_____City_____State_____Zip Code_____

***** Please send a copy of your insurance card*****

**Is your child taking any medications or vitamins? _____*
Please check any illness or conditions your child has **EVER had:*
Anxiety___Depression___ADHD___Autism___Anemia___Asthma___Heart Murmur___ Heart Condition___Diabetes___
Kidney/Liver___HIV___ Rheumatic Fever__TB___headaches__ Seizures___Concussions___OTHER___
****Does your child have any allergies**? **Yes**_____**No**_____if yes check all that apply: Penicillin { }*
Antibiotics { } Aspirin { } Foods { } Latex { } Resins { } Others { } _____

I consent and give permission for (me/my child or ward) to be treated by and to receive medical or mental health services (with or without my presence) from the Gateway School-Based Health Center (SBHC). I understand that such medical or mental health services may be provided by or at the direction of a nurse practitioner, physician, or mental health professional if the patient is a student I consent to and authorize the disclosure of patient information and records by the SBHC to the Gateway Regional School (School) and its agents and for the exchange of patient information and records between the SBHC and the School and its agents, which such patient information and records may include but is not limited to medical or mental health information or records that may relate to HIV, AIDS, venereal disease, psychiatric or mental health, alcohol or drug abuse, or communications with psychologists, psychotherapists, social workers, allied mental health providers, domestic violence counselors, or sexual assault counsel I also consent to and authorize the disclosure of patient information and records by SBHC to the patient's primary care provider and other providers for treatment purposes and to insurers and other third party payers for billing and payment purposes. I understand that my insurer may be billed for any services provided by SBHC to the patient and that my insurer may receive patient information and records as needed for billing and payment purpose. I may be responsible for any charges incurred by the patient that are not covered by my insurer including but not limited to deductibles and copays. I understand that the SBHC will disclose patient information and records as may be required by relevant law. This consent and authorization shall remain in effect as long as the patient is a student in the school, unless I rescind this consent and authorization in writing. I understand that, under Massachusetts law, there are certain circumstances where minors have the right to consent, on their own, to confidential diagnosis and treatment. These circumstances can include, for example, treatment of sexually transmitted diseases, pregnancy, substance abuse, mental health, and medical emergencies, or where the minor is married, a parent, or self-supporting. For such treatment authorized by minors only, the parent/guardian is not responsible for payment. In all these cases, the minor is encouraged to share information with the parent/guardian when appropriate. Please call the SBHC with any questions. **Your Privacy:** The School-Based Health Center complies with all federal and state privacy regulations (HIPAA). We will use your protected health information only for treatment and billing purposes, and we will obtain your permission before releasing your medical records except as may be requires by law. To read HIPAA information it is located on the Hilltown Community Health Centers website www.hchcweb.org or a copy can be mailed to you upon request by calling (413)667-0142

Parent Guardian Signature or Patient (Adult /Emancipated Minor) _____

Printed Name of Guardian or Patient (Adult/Emancipated Minor) _____

PLEASE TURN OVER AND SIGN THE PRIVACY FORM ON THE BACK

Hilltown Community Health Center

Acknowledgment and Release of Information Form

Print Patient Legal Name:_____ Date of Birth:_____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

By checking the following box and signing the bottom of this form, I acknowledge that I have received a copy of the Hilltown Community Health Centers, Inc. Notice of Privacy Practices by going to www.hchcweb.org.

☐ Received/Reviewed Notice of Privacy Practices

NOTICE OF PATIENTS RIGHTS ACKNOWLEDGMENT

By checking the following box and signing the bottom of this form, I acknowledge that I have received a copy of the Hilltown Community Health Centers, Inc. Notice of Patients Rights by going to www.hchcweb.org.

☐ Received/Reviewed Notice of Patients Rights

RELEASE OF INFORMATION

I HEAREBY AUTHORIZE THE STAFF OF THE Hilltown Community Health Centers, Inc. to render such services as may be deemed necessary to me. I also authorize the release of all NECESSARY information to insurance companies, other payers, and medical providers. I assign the Hilltown Community Health Centers, Inc. authority to claim and collect medical insurance on my behalf.

If the insurance information we have is incorrect, and your visit is **NOT** covered by your insurance, **you will be responsible for payment of this visit.**

PATIENT SIGNATURE: _____ Date: _____

(If patient is under 18 years of age, parent or guardian must sign)

If signed by other than patient, print name and relationship to patient

_____

Signee Name **Relation to patient**